COMMUNITY
Needs Assessment

2

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Medical Services Branch National Clearinghouse
Postal Locator 1920 A
Tunney's Pasture
Ottawa ON K1A 0L3

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ABOUT THIS HANDBOOK

Purpose

Handbook 2 provides details about developing and carrying out a community needs assessment for home and community care.

The Handbook is intended for community/tribal council/regional Inuit association planners and regional First Nations and Inuit organizations.

Using this Handbook

This Handbook is a guide. The steps outlined in the Handbook do not need to be followed in every way. Its goal is to support – not replace – the essential process of determining what will work best in your community. Importantly, the Handbook promotes the integration of community beliefs and values into the design of the program. In this regard, ***select the examples and suggestions in the Handbook that reflect the values in your community and are most appropriate for meeting your community's particular needs***.

The aim of the planning and development process is:

- to build an effective Home and Community Care Program;
- to provide services that meet the needs of community members;
- to ensure that the services can be provided as long as they are needed; and
- to establish a foundation for making the program better as the years go by.

The planning and development process for your Home and Community Care Program is designed to be community based and community paced.

This process is an ever evolving process that will ensure that home and community care services will continually seek new and innovative ways and means of responding to the identified needs in each First Nations and Inuit community.

INTRODUCTION

Identifying home and community care priorities and needs through a community needs assessment is an important activity that needs to be conducted at the beginning of program development. Whereas word-of-mouth can be helpful for getting the idea for the program going, **a needs assessment study provides a comprehensive and unbiased documentation of the needs in the whole community.**

As an example, in general conversation people may talk a lot about the need for homemaking services but never mention the problems that so many Elders may have in stabilizing their diabetes. The need for an emphasis and focus on diabetes issues and other needs in your Home and Community Care Program may only become evident through a more thorough study.

This Handbook provides a ***step by step approach*** to designing and carrying out a community needs assessment. Sample data collection tools are included as appendices to the Handbook and can be used as is or adapted to meet the specific needs of your community.

The data collection tools were tested by the sites participating in the Health Transition Fund (HTF) Project on First Nations and Inuit Home Care and were subsequently modified and refined based on their feedback.

Many of the lessons learned from the HTF Project are also reflected in the Handbook as ideas and suggestions which may benefit other First Nations and Inuit communities. As an example, the pilot sites have learned of the importance of community involvement and input into the planning and development of a new program, and the need for good communication throughout all phases of the process. As one site explained "without key support in the community, often best laid plans fail".

Please note that information gathered in the needs assessment process will remain with the community. A summary of the findings, however, will be submitted to the review structure in your region in conjunction with your service delivery plan.

In order to assist in developing a common understanding of terms used throughout the Handbook, a Glossary of Terms is included in the Planning Resource Kit.

Decide if You Have the Skills/Resources to Carry Out the Work

Yes

If your community has the skills to undertake the work, feel free to review the checklist in this Handbook and select and/or adapt the information that best addresses the needs of your community. Using the checklist, begin by setting reasonable timelines against each activity. Then review the checklist with your community leadership to ensure they support and agree with the list of activities.

No

If your community does not have the necessary skills and resources to carry out the needs assessment, you may want to consider:

- partnering with another community/region/band skilled in assessments. This could involve:
    - sending a staff member from your community to participate in and be mentored by a skilled staff member while they do their assessment; or
    - arrange with another community/region/band for a skilled staff member to come to your community so that he/she can jointly do the assessment and report with your staff.
- contracting with a consultant to discuss the objectives of the needs assessment, decide on the type of data you want to collect and have the consultant carry out the work.

Set Up Activities

Adopt or develop research ethical guidelines

Whether you conduct one survey or several in your community you must be able to assure people that the information they provide is going to be handled respectfully and that individual names will not be used or reported when it involves personal information. These and other similar topics are an important aspect of your needs assessment. Within research practice, they come under the heading of what is commonly called research ethics.

An example of community research ethical guidelines is attached as Appendix A.

Before proceeding with your community needs assessment you may want to review the ethical principles and standards that will guide your needs assessment. If your community does not have such guidelines, the following points can assist you in drafting the guidelines. Essentially, the guidelines should:

- Outline the general principles that govern research in your community. They should apply both to research that you conduct yourself and to research that outside agencies, such as universities, may ask to conduct in your community.
- Include the steps that will be taken in approving all research projects that relate to your program. Your management structure should review and approve all research plans before the research proceeds.
- Set out the criteria that will be used to assess and approve each research project, ensuring that each project meets an acceptable research standard.

- Include a full description of the procedures that are required for ensuring that people participating in the research have been informed about the purpose of the research and are participating willingly.
- Address such issues as how the information will be stored, who will have access to the data and to the results and how the data will be protected from inappropriate use or distribution.

Review these with your community leadership to ensure they support and approve the guidelines.

Coordinate Your Needs Assessment with Other Community Research

One of the important advantages of community-based research is that you can be more sensitive to the over-surveying that has occurred in most First Nations communities and Inuit settlements through the years. As much as possible you will want to coordinate your survey with other research being done by the community.

You may be able to piggy-back on each other's surveys. You may be able to add the questions you have into another survey and you may be able to make an arrangement for sharing information that others have already gathered. Generally speaking, people in your community will appreciate not being asked the same kinds of questions over and over.

Design and Carry Out Your Needs Assessment

Discuss the objectives of the needs assessment

In general, the objectives of a home and community care needs assessment are to:

- document community demographics and the health care infrastructure (i.e. the elements that make up your community health system);
- assess and quantify the needs and priorities for home and community care services in the community;
- document and assess training and capital needs related to home and community care delivery; and
- identify the impact of health care changes on the community.

The findings of your assessment will be used in the development of your service delivery plan, training plan and capital plan, and will provide the community with a base line of information to measure the impact of home and community care services for long term program planning and evaluation.

You may want to discuss these objectives and adapt or modify them in order to reflect your particular community situation.

Decide on the type of data you want to collect

You may want to brainstorm the type of data you want to collect through your needs assessment. The following are examples of data collected through the HTF Project needs assessment process:

- general background information on the community including its population, location, community health services and staff, relevant social services and access to off-reserve health facilities and services; and
- description of existing home and community care services and needs and gaps in the community, including training needs and gaps related to the effective delivery of home and community care services.

Develop or adapt collection tools

Once you have decided on the type of data you want to collect, you will need to develop and/or adapt collection tools to help carry out your needs assessment.

Sample data collection tools are attached as Appendices B, C, D, E and F.

Sample data collection tools are appended and can be used and/or adapted for purposes of your needs assessment. They were tested in the HTF Pilot Project on Home Care and subsequently refined and simplified based on feedback from the pilot sites.

Decide on the data collection methods you will use (e.g. the survey, the focus groups and the interviews)

- **A survey of current home and community based services and health needs**

  You may want to conduct a survey of the community as a whole in order to collect information about the existing home and community based services and the home and community care needs of a broad cross-section of people.

  If you have already conducted a health needs survey as part of the health pre-transfer process, some of the information can be pulled from that survey. Or if you are in the process of planning a community health needs survey as part of the health pre-transfer process then you may want to include your home and community care questions there.

- **Interviews with possible users of the service and key people knowledgeable of the issues**

  In developing your Home and Community Care Program, you may want to do interviews with the people likely to use the Program such as Elders, people with chronic illnesses and/or disabilities, family members, health professionals, First Nations/Inuit leadership, child and family services workers, taxi driver, medical taxi coordinator, and informal caregiver.

- **Focus Groups with Elders**

  The purpose of these focus groups is to facilitate discussion with and among Elders about their home and community care needs and about the services they think should be provided. Given that Elders are likely to have a high rate of need for home and community care services you may want to include as many of them as possible in the focus group. It is recommended that there be no more than 12 participants in each focus group session in order to ensure that everyone will have a better chance of participating in the discussion and expressing their views.

- **Focus Groups with other likely users of the services**

  You may also want to hold focus groups with other adults in your community who have disabilities and/or chronically ill, their caregivers and the caregivers of children who are disabled and/or chronically ill. If possible you may want to organize a focus group or one-on-one interviews with the children. Depending on the size of the community, and keeping to the recommended number of 12 per group, you may need to hold more than one focus group.

  Organizing the groups on the basis of the similarity of people's situations is a good approach to take. For example, the needs of young adults who are disabled are usually very different from those of either children or older adults, so organizing a group just for them could be useful.

- **Focus Groups with health care and social service providers**

  It is also a good idea to conduct a focus group with the health care and social service providers who serve your community. Some suggestions might be the local doctor, nurses, pharmacist, home care coordinators for the programs outside your community. The discussion should focus on the needs and gaps in home and community care services that they see in the community.

Regardless of which data collection methods you use, the quality of the information you end up with will depend upon the thoroughness and phrasing of your questions. You may therefore want to focus-test or try out the questionnaires with a sample of individuals to see if the questions are well understood and appropriate.

Review process with community leadership

Once you have established the objectives of your needs assessment and decided on the type and methodology for data collection, review the information with your community leadership to ensure they support and approve the needs assessment process.

Organize and carry out the data collection

Organize and carry out your data collection by setting reasonable timelines and deciding who will complete each component of the work. The person assigned to lead the needs assessment should review progress against the set timelines and make adjustments if necessary.

TIPS FOR ORGANIZING AND CARRYING OUT THE DATA COLLECTION:

- partner with bands/tribal councils or First Nations or Inuit who have gone through this step of the program development:
  - to share knowledge/skills
  - for your staff to learn from a mentor
  - to share your skills and lessons with others – become a mentor
- Contact the Coordinator in your region as questions come up for support or suggestions.

Analyze the Information You Have Collected

Sort and organize the information into categories, using charts as appropriate

The needs assessment identified several home and community care needs. To facilitate the analysis of the information you collected, sort, organize and prioritize the information into categories.

Appendix G provides some suggestions of how you might want to organize the information.

Review the information and discuss your understanding of it

Analyze the various information you have collected. This is an important part of your needs assessment process and will help to highlight your conclusions about the needs of your community in the final needs assessment report.

Prepare Your Needs Assessment Report

Prepare a report that summarizes the information you collected and your conclusions about the needs. The report should include a:

Sample Needs Assessment Summary Report is attached as Appendix G.

Description of the Needs Assessment Process

- Identify that the purpose of this needs assessment was to identify the home and community care needs.
- Explain the methods used to carry out the needs assessment.
- Explain the way the methods were used to carry out the needs assessment.
- Describe who participated in the needs assessment.
- Present the tools for collecting the information.
- Note any limitations in the process or with the tools used.

Description of the Community and Its Community Based Resources

- Describe the community and community demographics.
- Summarize the community based resources, including staff, facilities, visiting health professionals.

Summary of the Information Collected

Present the information according to the specifics of the data collection tool:

- If quantitative data was used, describe the use of statistics, charts and graphs.
- If qualitative data was used, regroup by themes, objectives, sections, etc.
- If closed ended questions were selected, provide the percentage or number of respondents by choice of response.

TIPS FOR IDENTIFYING RESPONSE TRENDS:

- Code and number each piece of information.
- Read all the answers to a given question before reading the answers to the next.
- Use the key word technique. In other words, write down the ideas that surface most often in the respondents remarks.
- Use a blank copy of the questionnaire to count the number of answers.
- Faithfully record the remarks, avoiding interpretation.
- Emphasize the answers that have the highest and lowest percentages.
- Highlight the percentage of "don't know" answers.
- Emphasize the connections between questions and answers.

Profile of the Existing and the Needed Services

- Highlight the information obtained by showing conclusions or trends. This means answering the following question: "What home and community care services do we have now and what services do we need to have?"
- Emphasize the gap between current and desired situations.
- Identify if training and/or education can help you address the existing and needed services.

Most Significant Service Gaps Identified

- Identify criteria for distributing needs in order of priority.
- Apply criteria to list the needs.
- Identify if training and/or education can help you address the most significant gaps identified.

Most Critical Training Requirements

- Where you have identified a training need (marked with yes in Sections 4 and 5 of Appendix G - Needs Assessment Summary Report), list type of training needed and the type and number of workers to receive the training.
- List training in order of priority.

TIPS FOR PRIORITIZING THE NEEDS:

Take into account the:

- importance (the number of respondents) placed on each answer.
- impact of the need on the population and the functioning of the community.
- feasibility of satisfying the need.

Review Results with Community Leadership

Before holding a community meeting to share the results of your needs assessment, review the information with the community leadership to ensure they understand and agree with the findings.

Hold Community Meeting

Communicate the results of your needs assessment with community members. If necessary, revise your report based on community feedback.

TIPS FOR COMMUNICATING THE INFORMATION:

- organize a community meeting in conjunction with a social event
- communicate the results in a community newsletter

SUMMARY CHECKLIST

ACTIVITIES	PERSON RESPONSIBLE	DATE COMPLETED
Set Up Activities		
Adopt or develop research ethical guidelines (refer to Appendix A for example)		
Coordinate your needs assessment with other community research		
Design and Carry Out Your Needs Assessment		
Discuss the objectives of the needs assessment		
Decide on the type of data you want to collect		
Develop or adapt collection tools (refer to Appendices B, C, D, E, F for examples)		
Decide on the data collection methods you will use (e.g. the survey, the focus groups, meetings and the interviews)		
Review process with community leadership		
Organize and carry out the data collection		
Analyze the Information You Have Gathered		
Sort and organize the information into categories, using charts as appropriate (refer to Appendix G for example)		
Review the information and discuss your understanding of it		

SUMMARY CHECKLIST (CONT.)

ACTIVITIES	PERSON RESPONSIBLE	DATE COMPLETED
Prepare Your Needs Assessment Report (refer to Appendix G for example)		
Description of needs assessment process		
Description of the community and its community based services		
Summary of the information collected		
Profile of the existing and the needed services		
Most significant service gaps identified		
Most critical training requirements		
Review Results with Community Leadership		
Hold Community Meeting		

APPENDICES

Appendix A - Sample Research Ethical Guidelines for Community Health and Social Development Research

Goal

To provide a framework and guidelines for doing health and social development research in [name of community], whether conducted by a community agency, individual members of the community or an outside institution or agency.

Principles

That the research respects the integrity and dignity of the individual residents of [name of community] and the community as a whole.

That health and social development research conducted in [name of community] contributes directly to achieving the stated health and social development goals and objectives of the community.

That the research methods which are used are consistent with the oral traditions of the community and validate the knowledge produced through community processes.

That health and social development research is organized and designed in a manner which includes the direct involvement of the community as represented by the [management structure].

That health and social development research conducted in [name of community] respects and promotes the practices of holistic health that are an inherent part of community culture and values.

That health and social development research conducted in [name of community] enhances the quality of life of individuals and the community as a whole.

That the research provides a real and concrete benefit to the community.

Objectives

To provide guidelines for the [management structure] to oversee the conducting of health and social development research in [name of community], including assessing proposals and directing the management of these research projects.

To ensure that health and social development research conducted in [name of community] is done in a manner which meets a high standard of community-based research practices; that these practices apply rigorous research methods; and that they produce demonstrably reliable results and knowledge that is validated by the community.

To conduct research in a manner which supports the development of research skills in the community.

To ensure that the research results are made available to community residents and that is understood that the knowledge which is produced belongs to [name of community].

Guidelines[1]

The organizers of the research project shall prepare a formal project proposal which shall be submitted to the [management structure].

The management structure shall review the proposal. Only those proposals which are approved by the management structure shall be carried out. In its review the management structure will consider the following factors:

- What is the purpose of the research? Is the purpose clearly stated in terms of why the research is needed and what questions will be addressed?
- How is the research likely to benefit the community?
- How will the research be conducted? Is the research design clearly described and understandable? Are the research staff appropriately qualified and trained?
- What data collection methods will be used? Are the data collection methods appropriate for the questions that they are intended to address?
- How will the data collection methods involve community members? How will those who will be responding to research surveys and/or interviews be informed about the research and informed about their right to decide if they want to participate or not? Will the participants (subjects) understand that they can withdraw from the research at any time?

[1] The guidelines which draw upon: a) the standards required by the Social Sciences and Humanities Research Council of Canada and described in ***Ethics Guidelines for Research with Human Subjects*** published by the Council; and b) the ***Ethical Guidelines for Research*** published by the Royal Commission on Aboriginal Peoples.

- How will the participants/subjects be selected? Is the selection method adequately and clearly explained?
- What methods and procedures will be in place to protect the confidentiality of participants and ensure their anonymity when they have provided personally sensitive information? Do these procedures meet community standards and practices?
- How will the research be organized? Who will manage the project? What will the role of the management structure be in managing the project? How will the management structure be kept informed about progress on the project?
- How will the research findings be reported back to the participants to ensure they are being interpreted appropriately?
- How will the research results and conclusions be shared with community and made available for use by the community?
- In what formats and methods will the research results be provided to the management structure?

The management structure will establish methods and procedures for storing the data, reports and other materials produced by research projects.

The management structure will establish policies and procedures for providing access to the results of research conducted within these guidelines. The procedures will take into account general community access, use by students and use by only researchers for other research purposes.

The management structure will assign responsibility for overseeing and administering access to research data to on member of the management structure.

Appendix B - Description the Community and its Community-Based Health Services

Introduction

The following tool will assist with documenting general background information on the community and its demographics.

Wherever possible, 1999/2000 data should be used and data from five years previous, e.g. 1995/96. In cases where 1999/2000 data is not yet available then the most current year data should be used and data from five years previous. You can choose to collect the information over a five year period if the data is readily available.

The following information should be available from your Band Manager and/or Community Health Nurse. If your community participated in the First Nations and Inuit Regional Health Survey (FNIRHS), you may be able to get information about education and other community health conditions (e.g. percentage of Old Age and Social Assistance Pension) from that source.

We suggest using Department of Indian Affairs and Northern Development (DIAND) population figures for this exercise, or, where updates have been maintained, the Community Workload Increase System (CWIS) population figures.

Please refer to the Glossary of Terms document for definition of terms used.

Table 1 documents population changes – using most current data available and data from five years previous. You may also wish to collect data on Band/community members living outside the community to determine if there is a shift in population and what impact, if any, this may have on long term planning processes for home and community care.

TABLE 1

DATA TO BE GATHERED	FIVE YEARS PREVIOUS (e.g. 1995/96)		MOST CURRENT DATA (e.g. 1999/2000)	
	MALE	FEMALE	MALE	FEMALE
Under 1 year				
1 - 4 years				
5 - 14 years				
15 - 24 years				
25 - 44 years				
45 - 64 years				
Over 65 years				
Total population in community				

Table 2 documents existing community health and relevant social services staff, visiting health professionals and distance from health facilities. Please refer to Glossary of Terms document for definition of terms used.

TABLE 2:

Existing Staff (both filled and unfilled positions) and Visiting Health Professionals	Indicate if: •full time (FT) •part time (PT) •visiting (V)	# of staff or # of yearly health professional visits	Community positions not filled	Travel time and distance in km from community to nearest health professional/ facility, if applicable
Community Health Nurse(s)				
Home Care Nurse Assessor/ Home Care Coordinator				
Home Care Nurse				
Health Coordinator/Director				
Homemakers/home support workers or other Adult Care Staff				
Home Health Aides/Personal Care Worker				
CHR(s)				
NNADAP Worker(s)				
Clerical Staff for Health (e.g. data clerk, receptionist)				
Other community health or social services staff (specify -- for e.g. BF/BHC Coordinator)				
Doctor				

TABLE 2 (CONTINUED)

Existing Staff (both filled and unfilled positions) and Visiting Health Professionals	Indicate if: •full time (FT) •part time (PT) •visiting (V)	# of staff or # of yearly health professional visits	Community positions not filled	Travel time and distance in km from community to nearest health professional/ facility, if applicable
Optometrist				
Dentist				
Physiotherapist				
Mental Health Professional				
Dietitian				
Diabetes Education Team				
Medical Specialists				
Other health professionals (specify -- e.g. first response team)				
Hospital				
Health Centre with medical care				
Personal Care Homes				
Level 3 & 4 Long Term Care Facility				
Ambulance Services				
Specialty Centres, e.g. dialysis centre, cancer treatment centre				

Table 3 documents facilities in your community. Please place a checkmark against the ones available in your community and whether they are accessible to persons with disabilities.

TABLE 3

Facilities in the Community	Accessible to Persons with Disabilities
• Community Health Centre	•
• Treatment Health Centre	•
• Nursing Station	•
• Health Station	•
• Personal Care/Nursing Homes (include # of beds)	•
• NNADAP Treatment Facility	•
• Elders Lodges	•
• Culture Centres	•
• Solvent Abuse Centres	•
• Band Office	•
• Hall	•
• School	•
• Other facility (please specify)	•

From the health data available in your community (Chronic Disease List, nursing records or other sources) document the number of community members who have the following conditions. Please use most current data available and data from five years previous. If you are aware that your community has experienced an increase in any of the health issues listed during the five year period, you may want to consider collecting the data for each year of the five period, e.g. 1995/96, 1996/97, 1997/98, 1998/99, 1999/2000.

TABLE 4

HEALTH ISSUES	Number of community members with this condition			
	Five Years Previous (e.g. 1995/96		Most Current Data (e.g. 1999/2000)	
Diabetes				
Conditions affecting the heart and circulation				
Physical disabilities/mobility challenges				
Emotional/Mental Disabilities				
Kidney Disease				
Severe Arthritis				
Cancer				
Other conditions with high occurrence in your community which impact the need for home and community care services				
People on Dialysis				

Table 5 captures information on housing conditions in your community. The information should be available from the housing department within your Band/community administration. While data on the housing conditions of potential clients will be obtained during the client assessment process, this data will provide you with a broad overview of the amount of services and staffing time that may be required to deliver services overall and the limitation general housing conditions may have on the safe delivery of services.

TABLE 5

HOUSING CONDITIONS	Number or percentage
Number of adequate houses	
Number requiring major renovations	
Number requiring replacement	
Percent with indoor plumbing	
Percent with running water	
Number of special needs housing	

For internal planning purposes only. Please identify existing health and relevant social funding available in your community. This information will remain with the community.

TABLE 6

EXISTING HEALTH AND RELEVANT SOCIAL FUNDING

Total funds provided by MSB for health, including home care nursing	
Total funding for in-home care (from DIAND)	
Total funding for institutional care (from DIAND)	
Funding for disabilities (all sources)	
Funding spent on mental health (NIHB)	
Building Healthy Communities funding spent on Mental Health	
Other Health Care Funding if applicable (please specify funding source)	

Funding Arrangement Status	**Check if answer is yes**
• MSB Standard Contribution Agreement	•
• Integrated Funding	•
• Pre-health transfer planning	•
• Health transfer negotiations	•
• Transferred (please indicate date of transfer)	•
• Self government	•
• Type of DIAND Funding Arrangement (explain)	•

The following questions collect information on the determinants of health and were asked as part of the First Nations and Inuit Regional Health Survey. This information may help to highlight the relationship between the determinants of health and the need for home and community care. If your community did not participate in the survey, please list the answers from any other sources available.

1. List the average highest grade achieved in elementary and high school.

   _____

2. List average number of people employed in your community.

   _____

3. The percent of the community who are on social assistance.

   _____

4. The percentage of people who are on Old Age Pension.

   _____

5. The percentage of people on disability pension.

   _____

Appendix C - Review of Current Home and Community Care Services and Needs in Your Community

This tool asks for information that will result in a detailed description of your current home and community care services and needs. It will also provide you with information on training needs that will assist with the development of your training plan.

The majority of this information should be available from the community based health and social service staff. If records or referrals have not been kept, refer to the expertise and experience of the health and social service team to estimate the number of clients seen, hours of service provided and by whom, and the number of community members who needed but did not receive care because of the lack of services.

TABLE 1

Home and Community Care ***Essential*** Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Client Assessment • assessment to make sure that the health care provided is based on the unique needs of each person • a care plan put into place to guide the services provided								
Managed Care • discharge planning • coordination with health and social service care providers								
Home Nursing • teaching to prevent secondary complications of existing disorders • post hospital care • wound management • lifestyle counseling • supervision of personal care • palliative care • medication management/ administration • foot care								
Home Support • personal care (e.g. bathing assistance, etc.) • homemaking • in-home meal preparation								

TABLE 1 (CONTINUED)

Home and Community Care ***Essential*** Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Medical Supplies and Equipment • assistance to acquire equipment to assist with independent living								
Program Management and Supervision								
Information and Data Collection								
In-Home Respite								

TABLE 1 (CONTINUED)

Home and Community Care ***Supportive*** Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Rehabilitation and Therapy Services								
Emotional Health (e.g. spiritual/ emotional support, wellness support, reassurance visits)								
Adult Day Programs								
Special Dietary Needs Requiring Diet Counseling								
Palliative Care								
Any other Home and Community Care Services								

TABLE 1

Home and Community Care *Essential* Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Client Assessment • assessment to make sure that the health care provided is based on the unique needs of each person • a care plan put into place to guide the services provided	23	69	R.N. 1 day per week. Shared position with other Bands within a tribal council.	Some clients have not been assessed in a timely manner because of limited availability of assessor	R.N. with Client Assessment Training	0	Assessment training update Basic Assessment Certificate	1 1
Managed Care • discharge planning • coordination with health and social service care providers	All clients	Included in Nursing and assessment time	This is done by either the Home Care Nurse or the Assessment Nurse	6 clients were discharged needing care with no discharge planning over weekends.	R.N.	0	Identified under Client Assessment and Home Nursing	
Home Nursing • teaching to prevent secondary complications of existing disorders • post hospital care • wound management • lifestyle counseling • supervision of personal care • palliative care • medication management/ administration • foot care	28	140	R.N. .5FT	12 clients required weekend services which was not provided due to lack of resources.	R.N.	0	Foot Care Certificate Diabetes Education Training Update certification for Vascular Access Devices Annual CPR certification First Aid every 3 yrs	1 1 1 1 1
Home Support • personal care (e.g. bathing assistance, etc.) • homemaking • in-home meal preparation	43	356	2 FT Home Health Aides 2 Part time Home Health Aides working 14 to 21 hours per week.	None known	Home Care Aide certificate or Home Care Special Care Aide Certificate	3	Home Care on the Job Training First Aid and CPR Communication Skills Palliative Care for Home Support Workers	3 4 4 4

TABLE 1 (CONTINUED)

Home and Community Care *Essential* Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Medical Supplies and Equipment • assistance to acquire equipment to assist with independent living	26	See Nursing and assess't time	Home Care Nurses order basic equipment and refer to Physio for specialized equipment	Several people have equipment which require repairs. The time and cost of sending them away for repairs could be managed better if repairs could be done locally.	R.N. Technician needed to repair equipment	0	Measurement for equipment Cleaning and disinfection of equipment. Repair and maintenance of equipment In service on types of equipment available and how to determine best choice for client.	1
Program Management and Supervision	5 staff	312 hrs	Home Care Supervision received from the Tribal Council	Supervision is often by telephone contact	Degree in Nursing	0	Ongoing education to maintain and improve supervisory and skills. Continuous updates or medical and nursing advances.	1
Information and Data Collection	all clients	168 hrs	2 FT clerk. This clerk is shared with other bands through the Tribal Council	Is occasionally late to submit stats due to heavy work load.	Certificate as secretary. Computer skills	0	Data Base Training Health Information System Training	1 1

TABLE 1 (CONTINUED)

Home and Community Care ***Supportive*** Service Elements	Description and Utilization of Services provided over the previous 12 month period				Education and/or Job Training Needed			
	Received Care in the Community			Number who Needed but did not Receive Care (Due to Lack of Services)	Minimum Training/ Education Required for the Service	Number of Staff who Require Training/ Education to Meet Minimum Requirements	Type of Initial and Future Training/ Education Required	Number of Staff per Training/ Education Session
	Number of Clients who Received Service	Number of Hours of Service Provided	Type and Number of Staff Providing Service (e.g. Nurse, Homemaker, etc.)					
Rehabilitation and Therapy Services	4	25	Physio and OT visit from District Health when invited by home care staff to provide rehab assessments and assess for complex equipment needs in the home.	2 clients find it difficult to access rehab services off reserve. These clients require intense rehab assistance in the home.	PT or OT. These are NOT First Nations employed.		Need to train exising home health aide as a rehab worker to assists clients with rehab program under the guidance of the PT	1
Emotional Health (e.g. spiritual/ emotional support, wellness support, reassurance visits)	0	Not known	Contracted services only available. Minimal access.	2 home care clients require but do not receive this support due to lack of services	Social worker with counselling	No staff in place at this time		
Adult Day Programs			Not available in next 6 months. Three staff will be hired.		Home Health Aide Certificate	2	Food Handling Recreation for the elderly. Home Care Aide on the job training	2 2 2
Special Dietary Needs Requiring Diet Counseling	14	1875 hrs	Dietitian 1.5 FT shared with five other First Nations through the Tribal Council	None known	Degree		Certified Diabetes Educator Annual Professional Conference to keep knowledge current	1 1
Palliative Care	2	51	All Home Care Staff provide this care as required	1 person required to provide services on weekends and evenings.	Basic job requirements as noted in Home Nursing and Home Support		Palliative care certificate for nurses Palliative care for home health aides	1 4

1. a) How many community members are living outside the community in special care facilities at the following levels? Refer to your provincial definition of levels of care or use the Glossary of Terms included in your Planning Resource Kit.

Response:

_____ level 1

_____ level 2

_____ level 3

_____ level 4

_____ level 5 (where applicable)

b) How many community members would likely to return to the community if home and community care services became available?

Response:

_____

_____

_____

2. How many community members were sent home from any institution or health agency without adequate discharge planning and referrals in the past 12 months? Has this changed over the past few years? What have been the impacts? Please describe.

Response:

3. Outline the impact that health reform has had on the community by identifying the changes and the impact of these changes. The following list may be used as a guideline only and can be modified to describe the unique situation of your community. The information gathered for this question may be very useful in explaining to the community why home and community care services are needed.

   a) Identify the changes in the larger health care system making reference to **any** of the following changes which are **relevant** to your community:

      - Early discharges
      - Acute bed closures
      - Health facility closure
      - Long Term Care facility closure
      - Expansion of day procedures and outpatient surgery
      - Changes in expectations for home and community care
      - Discharge planning changes/difficulties
      - Expansion of home care services in provincial/territorial health care system.

b) Describe how the above changes have had impact on your community. Some of the areas that you **may** wish to address are:

- the effects of health care reform on the community members
- how, if at all, has health reform affected the informal care givers
- workload changes for the existing health staff in the community
- changes in the amount and the complexity of care provided in the community
- changes in the expectation of the availability of home and community care services in the community

Response:

_____

_____

_____

_____

_____

Appendix D - Key Knowledge Person Survey - Interviews with Community Members and Health and Social Services Providers

The following questionnaire - the **Key Knowledge Person Survey** - can be used to gather the opinions of health and social services providers (such as nurses, Community Health Representatives, NNADAP workers, physicians and dentists) and community leaders (such as Chiefs, Councillors and Program Managers) on the health status and home and community care needs of your members, the health services required to meet those needs, and the most appropriate health management structure to administer the services.

Key informants should be selected for their experience and knowledge of the community and the service needs. Examples of people who may be selected to be interviewed could be the Health Portfolio Councilor, representative Elders, local hospital staff, taxi driver, the local doctor, local hospital staff, health committee representative. The most knowledgeable people in the health and social services field should be interviewed.

All information collected during this survey will be kept strictly confidential. No individual or organization should be identified in any way in summary reports.

Key Knowledge Person Survey

Introduction to the Survey

This survey is designed to obtain information for the purpose of program planning for home and community care services from persons who are knowledgeable about the specific issues in home care. A cross section of persons should be surveyed from knowledgeable community members, the leadership, the health and social development staff and from health and social services care providers outside the community.

All information collected during this survey will be kept strictly confidential. No individual or organization will be identified in any way in summary reports.

Thank you for your cooperation.

Section I: Background Information

1. What is your current position in relation to the health system or in the community? Check as many as apply to you.
   - Health Professional - position _____
   - Community staff or leader - position _____
   - Community Member
   - Person with diabetes or other chronic condition
   - Have a family member who needs home care services
   - Elder
   - Traditional Healer
   - Other – please specify _____
2. If you are currently working, what organization do you work with?

   _____

   _____
3. If you work with community members, how long have you been providing services to members of this Community?
   - Less than 1 year
   - 1 - 2 years
   - 3 - 5 years
   - 6 years or longer

4. Do you speak or understand the First Nations or Inuit language?

   - Yes
   - No
   - Some

5. a) Please provide a brief description of the health care services or programs that you are involved with or provide to community members.

   _____

   _____

   _____

   _____

   b) On average, approximately how many clients from the community do you see each month to provide health services?

   _____

   _____

Section II: Health Status

1. Regarding the general health status of the membership, in your opinion, what are the three most serious health-related problems of the community at the present time? If possible, please indicate the probable cause of each problem.

HEALTH PROBLEM	PROBABLE CAUSE
1	1
2	2
3	3

2. As a service provider or member in this community, what recommendations do you have to improve the health problems that you identified in the question above?

3. To what extent do you feel that adequate services are available to members of the community in each of the following areas:

SERVICE	Adequate	Needs some improvement or expansion	Completely inadequate/ not available
Home care nursing services	•	•	•
Assessment to make sure that the health care provided is based on the unique needs of each person	•	•	•
Discharge planning and referrals from services outside the community	•	•	•
Nursing care in the home to help people recover after hospitalization	•	•	•
Education for the prevention of complications of existing conditions	•	•	•
Support and care for persons who have chronic conditions	•	•	•
Personal care (assistance with self care such as bathing, etc.)	•	•	•
Homemaking or home management	•	•	•
Services to help persons with a disability to live independently	•	•	•
Rehabilitation services to help people maintain or regain abilities	•	•	•
Mental health services and therapy	•	•	•
Traditional health care	•	•	•
Assistance with meals	•	•	•
Dietitian Services	•	•	•
In home respite	•	•	•
Health information/awareness	•	•	•
Drug and alcohol treatment and counselling services	•	•	•
Equipment and aides for independent living	•	•	•
Other (please specify)	•	•	•

4. In your opinion, what are the three most serious gaps in health services in this community?

   1. _____

   2. _____

   3. _____

5. How do you suggest the three gaps identified above could be best addressed through the Home and Community Care Program?

   _____

   _____

   _____

   _____

6. Please describe the unique characteristics of the your community that should be taken into account in planning, managing and delivering home care services for community members.

   _____

   _____

   _____

   _____

7. Of the following listed, what do you think would improve the delivery of Home and Community Care services for the community? For example: (choose more than one if necessary)

- Better health management capacity in the community (such as a local health board, employee policies, professional liability insurance, etc.)
- Better contact between health service providers and the Band Council/community leadership
- More opportunity for peer interaction
- Identifying problems in the working environment (Please specify)

  _____

  _____

- More training or professional development opportunities
- Better access to equipment or resources
- Adequate health facilities
- Adequate funding
- Other factors (Please specify)

  _____

  _____

Comments:

_____

_____

_____

8. Do you feel that existing health services in your community are adequately integrated with other social, educational and community services in the community?

   - Yes
   - No
   - Not sure

   Comments: (suggestion for improvement if answer is no)

   _____

   _____

   _____

   _____

   _____

9. Do you have any additional comments on any issue that relates to the health of the First Nations and Inuit community?

   _____

   _____

   _____

   _____

   _____

10. Please describe any situation that you can recall in which a hardship was caused by a community member when there was no, or not enough, home care services available.

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to answer these questions.

Appendix E - Survey Tool for Community Members[1]

The following list of questions may be used to interview community members at large. It may be modified to include questions which are specific to your community. You may wish to interview people, have them fill out the form, or have a community meeting where a group of persons answer the questions together.

[1] The Survey Tool for Community Members was adapted from the Treaty 7 Home Care Project Questionnaire and the Long Plain First Nations Community Survey.

Home and Community Care
Community Members Survey

Please complete the following questions.

1. Check the following boxes that apply to you:

   - Male
   - Female

2. Age Group

   - Under 25 years of age
   - 26 - 39 years of age
   - 40 - 54 years of age
   - 55 - 64 years of age
   - 65 or older

3. I have a disability or chronic condition (one which does not go away).

   - Yes
   - No
   - Have a close family member with a disability or chronic condition

   If yes, what could be done to help you (or your family member) to stay living independently in your community?

   _____

   _____

4. I have been admitted to a hospital in the past year.

   - Yes
   - No

5. I have received home care services in my community in the past two years.

   - Yes
   - No

   If yes, what type?

   _____

   _____

6. I take care of a disabled or elderly person.

   - Yes
   - No

7. Please check the box that best reflects how you feel about the statement.

HEALTH STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not apply
I am healthy	•	•	•	•	•
I exercise regularly	•	•	•	•	•
I eat a healthy diet	•	•	•	•	•
My family help look after me when I am sick	•	•	•	•	•
My home needs repairs to make it safer for me to live there (e.g. ramps, etc.)	•	•	•	•	•
I need home care equipment in my home (e.g. wall bars, raised toilet seat, etc.)	•	•	•	•	•
I can get the type and amount of care I need to stay living at home	•	•	•	•	•
I am satisfied with home care nursing services I receive	•	•	•	•	•
I do everything I can for myself with the help of my family, and Home Care helps with things we cannot do	•	•	•	•	•
Family members should help when a person is sick	•	•	•	•	•
Home care should not replace the help the family gives	•	•	•	•	•

HEALTH STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not apply
The home care service is based on the health needs of the person	•	•	•	•	•
I have been discharged from hospital needing nursing care at home	•	•	•	•	•
I have been discharged from hospital before nursing service could be arranged for me at home	•	•	•	•	•
I (or my family) has received adequate home management services when needed	•	•	•	•	•
There are trained workers to help people who need help with their baths	•	•	•	•	•
I know who to call when my family needs home care help	•	•	•	•	•
Home Care services allows me (or my family member) to stay living in my own home more independently than if there was no home care services	•	•	•	•	•
The home care nurse visits my home when she/he is needed	•	•	•	•	•
I have been taught about my health problems by the nurse	•	•	•	•	•
I can contact a Traditional healer or native herbalist when I need one	•	•	•	•	•
I have been caused hardship because home care services were not available in the community	•	•	•	•	•
Home care services can be increased when I need more help or decreased when I can do more for myself	•	•	•	•	•
I feel that the home care staff care about me or my family member that receives care	•	•	•	•	•

8. To what extent do you feel that the following services are available to the members of your community?

Types of Home Care Services to be developed or changed	What we have is enough	Needs to be increased	Very much needed	Not Sure
Client assessment to make sure Home Care is based on a person's health needs	•	•	•	•
Health care givers are working with each other for the good of the client	•	•	•	•
Nursing care in the home (e.g. dressings, injections, teaching etc.)	•	•	•	•
Diabetes teaching and care	•	•	•	•
Foot care	•	•	•	•
Teaching to prevent complications of diseases or conditions	•	•	•	•
Home Management - help looking after the home	•	•	•	•
Personal care - help with such things as bathing, etc.	•	•	•	•
Meal Service - preparing meals for people who cannot cook for themselves	•	•	•	•
In-Home Respite Services - care for disabled people so the care giver can have a break	•	•	•	•
Do you think home care staff are trained, up to date and doing the jobs assigned to them?	•	•	•	•
Is there enough home care services available to support the family, if a dying person chooses to die at home?	•	•	•	•
Do you think that you receive care quickly enough after it has been requested? For example within 48 hours of the request?	•	•	•	•

9. If the community is able to expand the home care services beyond the essential services of client assessment, home support (homemaking and personal care) and home nursing, which three of the following do you feel is most needed in your community? Please check the **three most needed.**

- Adult Day Programs (care outside the home during the day)
- Meal Programs - such as meals on wheels
- Translation and medical escort for doctors appointments
- Transportation needs to medical appointments etc.
- Palliative Care Services for persons who wish to die at home
- Mental Health Services for home care clients
- Health Promotion, Wellness and/or Fitness Programs
- Rehabilitation and Occupational Therapy in the community
- Wellness Activities for the elderly and disabled
- Support Groups for persons with diabetes and other conditions
- Therapeutic Bath (specially equipped bath located in a common place)
- Health Classes and Workshops (please list what kinds)

_____

_____

10. What do you think is good about the home care services in your community?

11. Comments

Thank You for taking the time to fill this in.

Appendix F - Focus Group Questions

1. Are any of you or members of your family receiving any home care services at the present time? What kind of services are being provided? How often?

2. Are you happy with these services? Are they meeting your needs?

3. Are there any problems with these services?

4. Did you have any problems in getting these services?

5. What types of additional home care services would you like to see available in your community? Note to Discussion Leader: Provide examples if necessary.

6. Sometimes people need modifications to their homes or special equipment to make it easier to stay in their homes and live independently. Do you or any members of your family need any of these?

Appendix G - Summary Report

First Nations and Inuit Home and Community Care
Community Needs Assessment - Summary Report

Prepared for:

Prepared by:

Date:

1. Description of the Needs Assessment Process

Introduction:

- Identify the purpose of the needs assessment, e.g. to identify the home and community care needs

Methodology and Process:

- Explain the methods used to carry out the needs assessment
- Describe the way the methods were used (the process)
- Describe who participated in the needs assessment
- Present the tools for collecting the information

Limitations of the Needs Assessment:

- Note any limitations in the process and/or with the collection tools used

2. Description of the Community and its Community Based Services

Community Description:

Population	Summarize information in Table 1 – Appendix B
Location	Enter brief description of community, including geographical location and isolation factor
Housing Conditions	Summarize information in Table 5 – Appendix B
Other Socio-Economic Factors	Summarize information from questions 1, 2, 3, 4, 5 – Appendix B

Community Health and/or Social Services Staff and Facilities:

Community Staff	Summarize information in Table 2 – Appendix B
Visiting Health Staff	Summarize information in Table 2 – Appendix B
Distance to Health Facilities	Summarize information in Table 2 – Appendix B
Community Facilities	Summarize information in Table 3 – Appendix B

3. Summary of the Information Collected

Summary of Common Trends:

- Using the tips for identifying response trends (see page 16 in Handbook), summarize the common trends from your needs assessment

4. Profile of the Existing and the Needed Services

Using the information collected in:

- Table 4 – Appendix B
- Table 1 – Appendix C
- Key Knowledge Person Survey – Appendix D
- Survey Tool for Community Members – Appendix E
- Focus Group Questions – Appendix F

Highlight the information obtained by showing conclusions or trends. This means answering the following question: "What home and community care services do we have now and what services do we need to have?"

Emphasize the gap between current and desired situations.

Identify if training and/or education can help you address the existing and needed services.

Home and Community Care Essential Service Elements	Available in the Community?		Description and Comments (emphasize the gap between current and desired situation)	Can Training Help?	
	Yes	*No*		*Yes*	*No*
Formal client assessment process/tool	•	•		•	•
Managed Care	•	•		•	•
Home Support					
a) personal care	•	•		•	•
b) home management	•	•		•	•
Home Nursing	•	•		•	•
In-Home Respite	•	•		•	•
Linkages to other health and social services	•	•		•	•
Access to medical supplies and equipment	•	•		•	•
Program Management and Supervision	•	•		•	•
Information and data collection	•	•		•	•
Home and Community Care Supportive Service Elements					
Rehabilitation and Therapy Services	•	•		•	•
Emotional Health	•	•		•	•
Adult Day Programs	•	•		•	•
Special Dietary Needs Requiring Diet Counselling	•	•		•	•
Palliative Care	•	•		•	•

5. Most Significant Service Gaps Identified

Using the information collected in:

- Table 1 – Appendix C
- Questions 1, 2, 3 – Appendix C
- Key Knowledge Person Survey – Appendix D
- Survey Tool for Community Members – Appendix E
- Focus Group Questions – Appendix F

Identify the criteria for distributing needs in order of priority and apply the criteria to list the needs.

Identify if training and/or education can help you address the most significant gaps identified.

The following table is an **example** of service gaps and priority needs.

Service Gaps and Needs	Description of Service Gaps/Needs	Can Training Help?	
		Yes	No
Client assessment process issues		•	•
Discharge planning/hospital liaison issues		•	•
Issues identified around linkages and coordination		•	•
Home care services identified as needs		•	•
Personal care		•	•
Program management and supervision issues		•	•
Transportation		•	•
Medical Supplies and Equipment		•	•
Mental Health		•	•
Traditional Healing		•	•
Dietitian services		•	•

6. Most Critical Training Requirements

Where you have identified a training need (marked with "yes" in Sections 4 and 5 of the Community Needs Assessment Summary Report), in order of priority, list the type of training needed and the type and number of workers to receive the training.

The following is an **example** of training needs

Priority	Training Needed	Type of Worker to Receive Training	Number of Workers to Receive Training
1	Personal Care Training	Home Health Aide	3
2	Client Assessment Training	RN	1
3	Diabetes Education Training	RN	1
4	Foot Care Certificate	RN	1